UTAH DEPARTMENT OF HEALTH
288 North 1460 West Box #142104 Salt Lake City, UT 84114-2104 (801) 538-6191

Date: **Fax:** **To:**

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION ON THIS CLIENT:
Because sexually transmitted diseases are reportable to the Health Department, client consent to release this information to the Utah Department of Health is not required per Utah State Health Code 26-6-6.

Name:	DOB: Age:
Address:	Cell Phone:
City/State:	Home Phone:
Zip:	
Race: __White __Black __Other_____	Ethnicity: __ Hispanic __ Non-Hispanic
Sex: __ Male __ Female	Pregnant: __Yes __No EDC:_____
+ Lab Tests on date: (please attach all lab results)	

Tested + for: *Medication Needed (***please fill in what date medication given):***

Chlamydia ___/___/____ Azithromycin 1 gm PO one single dose, OR
___/___/____ Doxycycline 100 mg PO BID X 7 days

Gonorrhea ___/___/____ Ceftriaxone (Rocephin) 250 mg IM one single dose, OR
___/___/____ Cefixime (suprax) 400 mg PO one single dose

****if co-infected with CT & GC, please give two drugs: one for each disease****

Syphilis Primary & Secondary ___/___/____ Benzathine penicillin G 2.4 mil units IM (one dose)
Late Latent or Unknown Duration ___/___/____ Benzathine penicillin G 7.2 mil units total
(administered as 3 doses of 2.4 mil units IM each at 1 week intervals)

*See www.cdc./gov/std/treatment for complete treatment guidelines

Partner Name:	**Partner DOB/Age:**
Partner Treated: ___Yes ___No **Medication:**	**Date Given:** ____/____/____
Partner Address:	**Partner Phone:**

FAX INFORMATION TO: Bureau of Epidemiology @ Fax: (801) 538-9923

Office Employee Providing Information _____ (Please print)
Office Phone: (____) _____

Thank you!